A Critical Analysis of the National Health Care Insurance in Uganda

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Abstract

Mortality resulting from various illnesses in Uganda remains high despite numerous interventions. This is not that Uganda lacks qualified health workers and health facilities. This situation is attributed to a host of factors including inequity in the health services delivery which this article focuses on, specifically dwelling on the out of pocket payment for health care. Inequity in health service delivery has put Uganda's health care system on a continuous downward trend. As the government and other stakeholders are figuring out the possible remedy to salvage the health care system, this article proposes a National Health Insurance scheme for Uganda as an option. The main argument is that the national health insurance scheme will facilitate health care financing and address inequity in the health sector.

Key words: Health Care, Health Inequities, Out of Pocket Payment, Health Insurance

Introduction

The World's population has exceeded 7.2 billion, out of which more than 80% live in developing countries where the health care system is wanting and 90% of the word's deaths occur in Africa (Patwardhan*, Mutalik, and Tullu, 2014). Uganda's health care system was the best in the East African region in the 1960s. Its deterioration started with the political turmoil of 1970-1985. The current government of Uganda is trying to restore its glory amidst challenges (Mukasa, 2012). Globally health care systems are constrained, for instance the United States which spends 18% of its GDP on health still achieves inferior outcomes (King 2017). Many African countries like Nigeria, Ghana including Uganda undertook structural adjustment programs (SAP) of the World Bank and the International Monetary Fund whose main objective was to change the role of the state in social welfare from being a provider to a quality assurer (Konadu-Agyemang,2000; Kuyini 2013; Abukari, Kuyini, and Mohammed, 2015). With this approach, countries like Uganda decided to open crucial services like health to private entrepreneurs which resulted in gradual deterioration in quality of services. According to Abukari et al. (2015) and Mullins-Owens (2015), China, Thailand, Ghana and Singapore have had similar health care problems resulting from increasing population and demand for health care, delaine in health financing as an effect of SAP, but managed to revamp their once deteriorated health care systems using approaches that Uganda can emulate.

Health care in Uganda is provided by the government, private organization and the donor partners play a major role. Mukasa (2012) contends that under the private arrangement there is the Private Not for Profit organizations (PNFP), Private Health Practitioners (PHPs), Traditional and Complementary Medicine Practitioners (TCMPs) and the Public side consists of central and district health services under the local government. Health care in Uganda

is delivered at 3 levels including primary health care which is the first contact between the patient and the health care system where the patient receives preventive first aid care and immediate medical assistance, the second level which is secondary care, mainly emergency services, and the third is the tertiary care for specialized service (Mukasa, 2012). Even when the government cut its expenditure on social welfare and served as regulator according to the Structural Adjustment Program, it has not satisfied the public expectation in conducting its major role of quality assurer. The shift from a planned to a free market oriented economy has had a negative effect in terms of accessing health care services for the poor citizen all over the world (Mullins-Owens, 2015). For instance, in Uganda the introduction of cost sharing or user fee charges did not improve service delivery but affected the poor who cannot afford the fee. Uganda's health care is also characterized with health inequities which Margareta Whitehead (1992) described as avoidable differences but also considered unfair and unjust. In the mind of Whitehead (1992), equity in health care means equal access to available care, equal entitlement to the available services for everyone, equitable distribution of services across the country and removal of barriers to access health care services. Considering all these elements, equity cannot be guaranteed when health care is entrusted in the hands of the private sector.

Providing quality affordable health care is becoming more challenging that even attracting and retaining qualified health care professionals is not easy (Hale, Haley, Jones, Brennan and Brewer, 2015). This is evidenced by aged workers who are still in office when they are supposed to have retired. However, for the case of Uganda, except in the exceptional case of specialized cases, there is abundance of health workers eagerly seeking employment for the limited vacancies. The abundant potential workforce is not deployed because of inability to sustain the wage bill (Government (2010) which may be solved by intervening with a policy review and benchmarking to learn from other developing countries that have impressively managed health care financing. Currently, Uganda's health care financing is still below the Abuja 2001 declaration target of 15%. The government proposed the incentive scheme for health workers in the hard-to -reach areas which has been partly implemented but only 30% of the essential medicine and health supplies of basic packages are provided for in the framework for medium expenditure. Only 28 % of the health facilities in Uganda have a constant supply of medicines and health supplies (Government, 2010).

As countries start to realize the effect of structural adjustment programs on essential sectors including Health, calls for government to rescue Ugandans by adopting a health financing policy to enhance access to health care. While the SAP required the government to introduce user-fees or cash, many health economists and bioethicists advocate that the basic minimum health care services should be provided to all members of society (Aday and Andersen 1981).

Muhamedi (2015) asserts that national health insurance schemes are the best for the poor to access health care as they eliminate out-of- pocket costs and encourage populations to utilize the hospitals. There is a lot that policy makers can adopt or modify from health care financing systems in countries like China, India, Nigeria, Ghana, South Africa, Thailand and Singapore.

Purpose

This article aims at raising a platform to mobilize attention by providing a variety of options for intervention, facilitate evidence based lobbying policy makers to legislate comprehensive health care insurance policy for all categories of people to enable universal access to health care which will eliminate out of pocket payment for health services (Kwon 2011).

Methodology

This article is based on secondary data and observation mobilized through literature review and non-participant observation of the health care system in Uganda. During the study the researcher used a document review tool to select and analyze content of various articles secured from electronic search engines, physical libraries and institutional websites. The content analysis was careful and detailed, aimed at identifying patterns, themes and meanings emerging from the data.

Literature

Health care status in Uganda

One of the primary obligations of the government of Uganda is to provide health care services to the nationals in compliance with the minimum health package prescribed by the Sustainable Development Goal number five. For the government to fulfill this objective, it has to build capacity through infrastructure for health, human resources for health, sufficiently supply medicine and health supplies, enhance health financing, strengthen partnership for health and ensure equitable distribution of health care services. Worldwide, 150 million people are facing financial catastrophe and 100 million are suffering destitution due to out-of-pocket payment made for health care. 90% of these live in low income countries (Khan and Razvi, 2017). Out-of-pocket payment for health care services is the major financial barrier to accessing health care accompanied by shortage of human resources and geographical and cultural barriers (Kwon, 2011).

However, with all the government resources and support from the development partners for health, the image of Uganda's health care system is still tinted with inequities in accessing health care, such as shortage of drugs in facilities and on the other hand drugs rotting from stores, importation of expired drugs, under staff of health facilities and on the other hand high levels of brain drainage of health professionals, unemployment for health workers, strike of health workers for low pay, unaffordable cost for health care, embezzlement of donor funds of health, it is totally a confusion. The Uganda's free market economy has made health care access a market commodity where those who are financially well can afford higher out of pocket for health and access high quality private medical services and the poor are dying in the public facilities where the services are continued to deteriorate Kwon (2011) or have to give up treatment. Out of pocket payment drains most of the poor families in low income countries of Africa and Asia, hence catastrophic health expenditure.

If urgent action is not thought of to address the inadequate health care financing and inequities, this situation will leave the poor men and women and other vulnerable groups lying helpless. Furthermore, as the country is still in dilemma to solve the health care challenges, Uganda's population is expected to rise to 44 million by 2020 (UBOS 2017). Out of this population, 84.9 % live below the poverty line and cannot afford out-of-pocket health care services (Kamwesiga 2011).

The population of the poor presents a big burden on government to fulfill its obligation for which a strategic plan may be necessary to guide the government to achieve the sustainable development goal number five including sustainable health care financing. According to Kwon (2011) health care financing focuses on mitigating financial barriers to seek health care and to ensure system efficiency in a sustainable manner. Kwon further claims that through various models of health care financing, resources are mobilized from people of various status and are used to effectively purchase health care from providers. The uncertainty that characterizes Uganda's health care system can be addressed by developing a collective health care finance system which some countries have done through taxes and social health insurance (Yildirim* and Yildirm, 2011). Therefore, this article proposes National Health Insurance Models as policy options through which the government can finance and address inequities in the health care system.

Findings

Policy option One: Singapore Model (Three Tier Health Insurance Model)

Singapore like Uganda, experienced similar health care related challenges accruing from health care financing. By 2005, Singapore's total expenditure on health care was at 3.8% of GDP of which the government could account for 0.9% (Okma et..al 2010). The government came up with a three-plan health insurance model through which the government paid for citizen's medical care services. The three tier health insurance plans include Medisave, Medishield and Medifund. According to Okma et al. (2010) these plans entail the following packages:

The Medisave which was introduced in 1984 as an extension of the Central Provident Fund (CPF) is a compulsory, tax-exempt, interest yielding Pension saving scheme. The plan depends on individual's paycheck in pre-tax dollars and is kept for the beneficiaries to use in their health care needs. To ensure health care for women, children and elderly who may not be in the working category, this fund may be utilized to pay for hospitalization of spouses, children, siblings or parent.

Medishield on the other hand is a voluntary program that provides low-cost (government subsidized) health care for catastrophic illness coverage. Individuals can use their Medisave funds to pay premium for this program if they choose. On the contrary Medifund, which is a government funded safety net program, provides health care coverage for those unable to pay for the care without Medisave or Medishield or having missed out their coverage under other plans. Okma asserts that it is through the Medifund program that the government can ensure equity more especially for the poor as the big proportion of the population is unable to

contribute to their own health saving programs.

Policy Option Two: The Thailand Model (The 30 Baht scheme)

According to Sakunphanit (2016), Thailand's national health insurance is constructed on three pillars that lines with the employee status of the Thailand people that's public service, private and informal sector.

The Civil Servant Medical Benefit Scheme (CMBS) is a comprehensive cover to all current and retired state and federal employees and their parents, spouses and children; the Social Security Scheme and Worker Compensation Scheme (SSS & WCS) covered people in the private formal sectors funded by the employee, employer, the government and Universal Coverage Scheme (UCS) which is for informal sector, unemployed students, disabled, veterans and monks (Sakunphanit, 2016; Mohamedi et al. 2015). To ensure that everybody has equitable health care, the Thailand government in 2001 introduced the universal coverage also known as the 30-Baht scheme to cover everyone left out by the established insurance plans. Countries like Japan, Korea, Taiwan and Thailand provide health care insurance coverage for the entire population depending on the breadth and depth of benefit coverage (Kwon 2011).

Policy Option Three: Private Health Insurance

With the limited resource basket, Uganda can still develop a policy on national health insurance through Public Private Partnership's collaboration for Health Care, since for instance PNFP facilities account for close to 50% of the total health care service in Uganda (Oketcho, Ezati, Odaga, Foster, McMahan, & Muldavin, 2015). Public -Private Partnership (PPP) according to Koppenjan (2005) is a form of structural cooperation between public and private partners in planning construction or exploitation of infrastructural facilities in which they share or reallocate risks, costs, benefits, resources and responsibilities. Singh & Prakash (2010) affirms that public- private partnership are becoming a global approach to address health care issues not only in provision of health care services but even at targeting a wide range of health care issues.

It is therefore believed that through collaborative relationships between the government and the private actors in the field of health care can bridge the gap between demand and supply of health care services through addressing some of the challenges of health care systems (Chatterjee and Laha, 2016). A private health insurance under this collaboration is based on principles of competitive market for health care in order to ensure economic efficiency and fairness (Odier 2010). Fairness here means access to health care, differentiated by the terms of the contract between the individual and the insurance and the rule of free market economy. These should regulate this relation between the health insurance companies and between the care provider for better coverage at minimum cost.

An insurance public-private partnership is also seen as a contractual agreement between the government and private service providers in which the private partner intends to work with the government to achieve public policy objectives in a cost-efficient and effective way (Ramm 2010). In countries like the United States of America (USA), large companies offer private insurance as part of their contract with the aim of attracting and keeping valuable

employees. Government of Uganda can also promote PPP for health care and contribute a percentage for Ugandans.

Discussion

Policy Option One: Singapore Model (Three Tier Health Insurance Model)

Under the three tier health insurance model, the country adopts a single insurer associated with a well-structured system of consumer co-payment and health care insurance is equitably managed at low cost. It is also assumed that adopting this policy option will reduce household vulnerability to high health care cost through directly reduced medical costs. Where health insurance has been adopted, it has increased patients' access to timely hospital care in the health care system. For example, in Organization for Economic Cooperation and Development (OECD) countries, it has been observed that there is no waiting time for elective surgery irrespective of the main form of insurance coverage (Tapay, 2004).

Option Two: The Thailand Model (The 30 Baht scheme)

The adoption of national health insurance policy is associated with decline of causes of death considered amenable to health care. However, implementation of option two and three may result into compliance costs that will be incurred by the employer be it government or private firms as both are required to contribute to the insurance premium of their employees. Additionally, costs may arise from implementation of the proposed insurance plans especially in the informal sector as a number of inspectors will have to be recruited and trained to competently enforce the insurance schemes. Facility utilization is likely to rise as the number of people seeking medication increases.

Option Three: Private Health Insurance

The private insurance scheme provides an alternative coverage for populations ineligible to public insurance schemes and bridges the gaps created in public system coverage. Through this scheme, more resources are injected in the health care system resulting into expansion in capacity and service delivery. Secondly, it is believed that private health insurance through public private partnership will relieve public hospitals and lead to efficient and effective performance. Partnering with private hospitals is likely to increase the capacity for these facilities to handle complicated health challenges and reduce volume of clients in public facilities which provides opportunities for better pricing and beneficial competition.

Partnership with private facilities can change the exposure of the population to risk, making insurance protection sustainable for both insurers and reinsurers. Though private health insurance is desired as it will increase access to health care, private insurance is a high cost and inequitable mechanism and lacks the incentives or capacity to control moral hazards and to contain health care costs (McAuley, 2016).

Government is likely to incur high bureaucratic cost when health funding is churned through private corporate financial intermediaries. The adoption of private health insurance presents a threat to equity, availability and accessibility of health facilities especially to the

vulnerable. This option will require a great vigilance in the private sector since there are many actors and institutions likely to default on accountability in absence of a rigorous registration and licensure system (Chapman 2014).

Conclusion

The core characteristic of health related vulnerability is that the individual faces significant obstacles to receive appropriate medical treatment and prevention services. Children, the elderly, women not in gainful employment and immigrants are the vulnerable groups of people that the policy options are targeting. These categories of people will benefit from the policy options. If the private insurance policy option is adopted by the government as a means of providing health insurance, the children, the elderly, the women not in gainful employment and immigrants are likely not to benefit as they may not be in position to pay the premium, or to make meaningful decisions as the market economic dynamics may not be in their favor. Consequently, the government should endeavor to benchmark where the policy options have been applied and gauge their feasibility in the context of Uganda.

Recommendation

To ensure compliance to any alternative that would be chosen, both the government and private employers should remit their contributions to the regulatory authority at a specified date and penalties should be applied where non-compliance is noticed. This will be supported by the existing laws and guidance on disclosure and noncompliance.

An independent oversight body should be established to monitor and promote compliance and serve as the quality assurance with the requirements or the agreed terms under which private insurance will be provided by public private partnership. The authorities charged with this role should be adequately facilitated in terms of institutional capacity, authority and independence from political pressure.

Structures of monitoring and evaluation need to be embedded in the design of these agreements at the onset indicating the key indicators, process of data collection that would be compared to the initial baseline studies regarding the situation of the targeted beneficiaries.

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